National Coalition of State Alcohol and Drug Treatment and Prevention Associations

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Testimony Before the

House Commerce Committee

on

Reauthorization of SAMHSA

Drug and Alcohol Treatment and Prevention Programs

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Presented by

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on behalf of the

National Coalition of State Alcohol and Drug Treatment and Prevention Associations

Substance Abuse: We Can Prevent It. We Can Treat It. We Can't Ignore It!

Good morning. My name is Art Schut, and I am President of the Iowa Substance Abuse Program Directors' Association and Executive Director of the Mid-Eastern Council on Chemical Abuse, a drug and alcohol treatment provider in Iowa City.

Thank you for the opportunity to testify about the reauthorization of drug and alcohol treatment and prevention programs in the Substance Abuse and Mental Health Services Administration (SAMHSA). I ask that my full written statement be included in the hearing record.

I am testifying today on behalf of the National Coalition of State Alcohol and Drug Treatment and Prevention Associations, a coalition of 34 state treatment and prevention associations in 30 states around the country. These associations represent providers on the front lines of treatment and prevention who daily confront the dramatic need to maintain and strengthen services for individuals and families with drug and alcohol problems.

The thousands of programs represented by these associations have been supported, in part, through federal funds. They provide services to children in families where parents are addicted, pregnant women with drug and alcohol problems who want a better future for their children, and addicted individuals in the criminal justice system who want a new start in life. These programs are reducing child welfare costs by restoring families, saving Medicaid dollars by helping low-income pregnant women deliver healthy babies, and preventing criminal recidivism by treating criminal justice offenders.

Alcoholism and drug dependence are among our nation's most serious health problems. Untreated, they cost us at least $166 billion, or $700 for each American annually in health care,

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criminal justice, social, and lost productivity costs. They contribute significantly to HIV/AIDS, birth defects, homelessness, injury, crime, violence, and child abuse and neglect. They also fuel the rapid rise in health care, welfare, criminal justice, and child welfare costs.

The Treatment and Prevention Gap in Our Communities Is Growing

Too many of our schools and communities simply lack adequate prevention resources. This has been made startlingly clear by increasing drug and alcohol use among teens. The most recent "Monitoring the Future" study found increasing marijuana, alcohol, and tobacco use among eighth graders and increased marijuana and tobacco use among 10th graders.

Unmet treatment need has never been greater, and the public treatment system cannot accommodate all those who want and need help. Current capacity can treat roughly 1.4 million drug users. In 1990, the Institute of Medicine estimated that 5.5 million Americans needed treatment.

Since then, demands on the public treatment system have increased. More Americans have no private health insurance, and economic incentives in the insurance market encourage private insurers to limit care for drug dependence and alcoholism, forcing people with these diseases into the public treatment system.

Recently enacted entitlement reforms will further increase the pressure on public treatment resources.

Legislation enacted last March (P.L. 104-121) ended the eligibility of individuals whose only disability was drug dependence or alcoholism for Supplemental Security Income (SSI). As a result, more than 140,000 Americans with drug and alcohol problems will also lose their

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Medicaid and access to any Medicaid-financed treatment services they were receiving. Their only choice will be to turn to SAMHSA funding for treatment.

The new welfare reform law will also increase the demand for treatment services in the public system. Studies estimate that between 10 and 20 percent of public assistance recipients are impaired by alcohol and/or drugs. Without treatment, they will not be able to find and keep jobs or support their children. This is something state and local welfare directors recognize, and 65 percent those surveyed told the Legal Action Center that treatment services were "extremely important" to welfare reform. Yet the new law provides no new money for treatment and actually makes it more difficult for women on welfare to get treatment.

The new welfare law denies cash assistance and food stamps to anyone with a drug felony conviction -- for possession, use, or distribution -- after the date of enactment. Few policy makers recognize, however, that residential treatment programs for women with children have relied on these funds to pay for their clients' room and board and could be forced to reduce services or close without them. One Florida program has estimated that 80 percent of its clients have drug felony convictions. In a ongoing survey by the Legal Action Center, many treatment providers have expressed their expectation that welfare reform will increase the number of clients seeking services while decreasing the resources available for treatment.

Treatment and Prevention Are Effective

We have never had so much data demonstrating the effectiveness and cost-effectiveness of treatment and prevention. The most recent outcome study grew out of the SAMHSA demonstration programs whose reauthorization we are here today to discuss. The 1996 National

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Treatment Improvement Evaluation Study (NTIES) evaluated 78 treatment programs funded by the Center for Substance Abuse Treatment (CSAT). I ask that copy of the study be included in the record of this hearing.

The NTIES study found sustained reductions in drug use and criminal activity, increased employment, and decreased welfare dependence among 5,700 individuals one year after they completed treatment. Specifically:

- Crack use decreased by 50.7 percent.
- Heroin use decreased by 46.5 percent.
- Criminal activity decreased, with a 78.2 percent drop in selling drugs, an 81.6 percent drop in shoplifting, and a 77.6 percent drop in beatings.
- Employment increased by 18.7 percent.
- Welfare dependence decreased by 10.7 percent.
- The number of individuals who had sex with an injecting drug user or exchanged sex for money or drugs dropped by more than 50 percent.

Other studies -- for example, by the States of California, Minnesota, and Oregon -- have documented similar successful treatment outcomes.

Evaluation studies have also found prevention programs to be effective:

- A 1995 Cornell University study of 6,000 junior high students in New York State found that students who participate in school-based prevention programs are 40 percent less likely to use alcohol and drugs than those who did not participate.
- The National Structured Evaluation, an evaluation of services provided in more than 2,300 prevention programs across the nation between 1980 and 1993, found that a variety of approaches, including counseling, peer leadership, stress management, skills development and other techniques, effectively prevent alcohol and drug use.

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Congress Must Ensure that SAMHSA Programs Stay Strong

Programs supported by SAMHSA are the first line of defense to protect our children from developing drug and alcohol problems, as well as the funding source of last resort to treat Americans who have already developed drug and alcohol problems. As a society, we cannot afford *not* to keep these programs strong, manageable, and accountable. The National Coalition offers the following three principles to guide your work on SAMHSA reauthorization:

- Congress should maintain the current law's balance of flexibility and accountability and focus reauthorization on strengthening the substance abuse block grant and ensuring that categorical and demonstration programs support the community-based services infrastructure.

- Congress should resist calls to re-structure these programs in any way that will cause a loss of funds over the next few fiscal years or reduce the Federal presence and voice on these issues.

- Congress should maintain its commitment to a singular Federal agency that focuses on drug and alcohol treatment and prevention. SAMHSA plays a crucial role in filling the gap left by the traditional medical system, which has failed to prevent, identify, or treat drug and alcohol problems adequately.

Keeping these three principles in mind, the National Coalition offers these specific recommendations on SAMHSA reauthorization.

I. Substance Abuse Block Grant

A. Maintain an Adequate Level of Federal Oversight of the Block Grant

The majority of SAMHSA's funding for drug and alcohol treatment and prevention is channeled directly to states through the Substance Abuse Block Grant. Funded at $1.36 billion in FY 97, the Block Grant is the primary source of federal funding for alcohol and drug treatment

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and prevention services, accounting for more than one-third of public funding for these services nationwide.

Last year, the Administration proposed converting the Block Grant into a Performance Partnership Grant (PPG). Under a PPG, each State would set program goals and objectives, performance measures, targets, and time frames, and negotiate a performance agreement individually with the Secretary of HHS.

We continue to oppose PPGs or any similar concept that would drastically reduce federal oversight of the delivery of taxpayer-financed treatment and prevention services. We are pleased that the Administration has reconsidered and is asking for approval from Congress to proceed more slowly.

While we believe in the need to move toward outcome-based performance measurement, as PPGs are proposed to do, we urge Congress to proceed with caution. Careless selection of measures, for example, could encourage reductions in funding for programs working with the hardest-to-serve clients -- such as pregnant women, women with children, the chronically addicted, and youth living in high-risk environments.

B. Retain Important Block Grant Set-Asides

We support the Administration's proposal to retain many of the set-asides in current law and allow some to be waived by the Secretary of HHS at state request. As described by the Administration, waivers could be granted to States that were moving toward performance measures (including capacity, process, and outcome) that had been developed through a negotiated process involving constituency groups in the drug and alcohol treatment and

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prevention fields. We encourage Congress to consider this approach, but also to ensure that treatment and prevention providers are included in the measure development process.

About the substantive spending requirements, we support the Administration's proposal to:

1. Retain the 20 percent set-aside for primary prevention services.

Recent documented increases in drug use among adolescents make retaining this set-aside crucial. We simply cannot afford to compromise this important source of funding for prevention and early intervention programs, which have been proven to be highly effective and to save enormous sums of money.

2. Retain the women's set-aside, which requires states to maintain FY 94 spending levels for treatment services for pregnant women and women with children.

The women's treatment infrastructure supported by this earmark is only in its infancy and still desperately in need of support. Studies continue to identify acute gaps in services for pregnant women and women with children. This set-aside is also needed now more than ever because changes in the welfare system will shrink the funding available for women's services, as I discussed earlier, and so will reprogramming of SAMHSA demonstration grants from services to knowledge development, which I will discuss later.

3. *Retain the HIV/TB set-aside.*

In 1994 and 1995, 75 percent of new HIV infections were among drug users. Of those diagnosed with AIDS, drug use is linked to more than 35 percent of adult cases, 66 percent of women's cases, and more than 50 percent of pediatric AIDS cases. Individuals with

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compromised immune systems are also at risk for contracting TB. Individuals in drug and alcohol treatment must continue to have access to health and other services to address their multiple health needs, particularly HIV and TB.

C. Retain the Needs Assessment Process

The 1992 law strengthened State data collection and reporting requirements and required States to conduct a needs assessment to determine their treatment and prevention needs. This process should be retained, and we are pleased the Administration has proposed doing so. The needs assessment process will be particularly useful in providing baseline data for the transition into an outcomes-based system.

D. Prohibit Transfers Between the Mental Health and Substance Abuse Block Grants

Reauthorization bills considered last year would have allowed States to transfer up to 10 percent of their Substance Abuse Block Grant into their Mental Health Block Grant and vice versa. We continue to oppose a transfer authority and support the Administration's decision not to seek one in its current reauthorization proposal.

This fiscal year (FY 97), the Substance Abuse Block Grant is almost five times larger than the Mental Health Block Grant. A 10 percent transfer from the Substance Abuse Block Grant would be, nationally, a 50 percent increase in the mental health block grant (from $275.4 to $411.1 million), while transferring 10 percent of the Mental Health Block Grant would increase the Substance Abuse Block Grant by only 2 percent (from $1.360 to $1.387 billion). In addition, the Substance Abuse Block Grant constitutes a much larger percentage of overall

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services funding than does the Mental Health Block Grant. Consequently, this type of proposal could dramatically disrupt the availability of drug and alcohol services.

When Congress separated the Mental Health and Substance Abuse Block Grants in 1992, it allowed States that lost a portion of their FY 93 or 94 mental health block grant funding relative to their FY 91 allocation to transfer the difference from their substance abuse block grant allocation (and vice versa). But because the two block grants have been separate for five years, this protection is no longer needed. Money directed by Congress for substance abuse programs should not be diverted to mental health programs and vice versa.

States also should be limited in their ability to fold substance abuse block grant funds into State health care reform through the Medicaid waiver process. Unless their waiver program funds comprehensive drug and alcohol treatment services, States should not be permitted to merge block grant and Medicaid funding. We cannot afford to lose the safety net the block grant currently provides for Medicaid recipients with drug and alcohol problems whose treatment needs are poorly served in the Medicaid program.

E. Maintain Ineligibility of For-Profit Organizations for Block Grant Funds

Reauthorization bills considered last year would have allowed for-profit organizations to be eligible to receive Block Grant funds. We opposed this expansion last year and support the Administration's current proposal to maintain the prohibition.

The Substance Abuse Block Grant is a safety net for all Americans with drug and alcohol problems. Block Grant funds, which are taxpayer dollars, should continue to support services and not be siphoned off to profit shareholders of private corporations.

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Private insurance companies in general, and managed care organizations in particular, have limited experience covering drug and alcohol treatment and prevention services. For-profit organizations have a financial incentive to undertreat individuals, also allowing them to transform "savings" into profits for their shareholders. The private insurance system has been "dumping" clients into the publicly funded system for years and there is no indication that for-profit entities will provide the comprehensive care needed by many individuals.

For example, an audit of managed substance abuse and mental health benefits for employees of the State of Ohio found that the for-profit managed care organization kept 70 percent of the money it had received from the State for profits, spending only 30 percent on treatment, although it had promised to spend 64 percent on treatment.

Nonprofit treatment and prevention organizations have also demonstrated more economy with Federal taxpayer dollars in other ways. Research has shown that publicly financed clients tend to be concentrated in treatment modalities, such as non-hospital residential and outpatient settings, that cost less than settings historically reimbursed by private insurance.

F. Transfer Synar Anti-Tobacco Provisions to FDA

The 1992 law imposed new requirements on States to enforce laws to prohibit the sale of tobacco products to minors. If States fail to comply, they can lose up to 40 percent of their substance abuse block grant funds. While we recognize the importance of reducing tobacco use particularly among adolescents, the ultimate losers here are treatment providers and their clients. This is monumentally unfair, especially given that treatment providers have no control over enforcement of this provision.

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We recommend that the requirement to enforce tobacco laws be transferred to the Food and Drug Administration (FDA). This will avoid duplication and ensure program balance and coordination, as the FDA is undertaking significant tobacco regulatory activities.

G. Authorize the Block Grant at $2 Billion

Congress must maintain strong support for the Substance Abuse Block Grant, and we recommend authorizing it at $2 billion. The FY 97 appropriation is $1.36 billion, and we must leave room for appropriations to increase as needed.

II. Demonstration Programs

A. Demonstrations Should Focus on Community-Based Services, Not University-Based Research

Last year, the Administration restructured demonstration programs at the Center for Substance Abuse Prevention (CSAP) and Center for Substance Abuse Treatment (CSAT) into "knowledge development and application" programs targeted at research instead of services. Historically, these programs had directly funded community-based providers filling critical service gaps for, among others, pregnant women, women with children, people involved in the criminal justice system, the homeless, youth in high-risk environments, community-based prevention partnerships, and the workplace. Now, however, they are funding university-based research, and the restructuring is translating into a loss of direct, community-based prevention and treatment services.

The demonstration programs had been crucial components of the treatment and prevention infrastructure and absolutely necessary to our ability to test and disseminate effective

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program innovations. Without them, we would never have the data I related earlier from the NTIES study about how effective federally funded treatment programs are. We urge Congress to articulate clearly that the KDAs should focus on applying and disseminating new research findings and new technology, rather than duplicating services research being conducted at the National Institutes of Health.

B. Authorize Demonstrations at $250 Million Each and Urge Full Funding

The President has requested $307 million ($151 million for CSAP and $156 million for CSAT) for KDA activities in FY 98, which is still nearly $140 million below FY 95 levels ($87.6 million less for CSAP and $52.4 million less for CSAT). We recommend that each KDA be authorized at $250 million and fully funded.

We urge Congress to stay committed to funding services-based information gathering to improve and expand the treatment and prevention system. These programs are needed because they can respond quickly to changing needs, particularly in areas that cross State boundaries.

Conclusion

As I stated at the outset, SAMHSA programs must stay strong, manageable, and accountable. They are the first line of defense to protect our children from developing drug and alcohol problems, as well as the funding source of last resort to treat Americans who have already developed drug and alcohol problems. As a society, we cannot afford *not* to prevent and treat drug and alcohol problems.

Thank you for the opportunity to appear before you today. I am happy to answer questions.

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